INdiana Scheduled Prescription Electronic Collection & Tracking Program

Transmittal Form

Date: _____

Pharmacy Information: **Transmission Type:**

NCPDP#:_____ **Disk/Paper:** _____

Name: _____

Address: _____

City: _____

State: _____ **Zip:** _____

Telephone: _____ **Contact:** _____

Number of Prescriptions Included: _____

Date Range - from:_____ to: _____

PLEASE COMPLETE THIS FORM AND
INCLUDE WITH YOUR DISK OR PAPER FORMS

MAIL TO:
Controlled Substances Advisory Committee
ATTN: INSPECT Program
402 West Washington Street Room W 072
Indianapolis, IN 46204

FAX:
317.233.4236

Email:
ded@pla.in.gov

(Please keep a copy of this form for your records and make copies for future use)